CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|---|---|--|--------|----------------------------|--|---------|--------------------|--|
| AND PLAN OF CORRECTION | | | | LDING | 01 | COMPI | | |
| | 155086 | | B. WIN | | | 04/20/2 | U I I | |
| NAME OF PROVIDER OR SUPPLIER | | | | | ADDRESS, CITY, STATE, ZIP CODE | | | |
| WOODLAND MANOR | | | | 1 | NAPPANEE ST RT, IN46514 | | | |
| | | | | | 111, 11140514 | | | |
| (X4) ID PREFIX | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | DATE | |
| K0000 | | · | | | | | | |
| | | | | | | | | |
| | A Life Safety (| Code Recertification | K(| 0000 | | | | |
| | and State Lice | nsure Survey was | | | | | | |
| | conducted by t | the Indiana State | | | | | | |
| | _ | Health in accordance | | | | | | |
| | with 42 CFR 4 | | | | | | | |
| | | 103.10(a). | | | | | | |
| | G D | 0.4/20/11 | | | | | | |
| | Survey Date: | 04/20/11 | | | | | | |
| | | | | | | | | |
| | Facility Numb | | | | | | | |
| | Provider Numl | ber: 155086 | | | | | | |
| | AIM Number: | 100274880 | | | | | | |
| | | | | | | | | |
| | Surveyor: Richard D. Schade, Life | | | | | | | |
| | Safety Code S | · · · · · · · · · · · · · · · · · · · | | | | | | |
| | | poorume | | | | | | |
| | At this Life Sa | fety Code survey, | | | | | | |
| | | nor was found not in | | | | | | |
| | | | | | | | | |
| | | th Requirements for | | | | | | |
| | Participation in | | | | | | | |
| | Medicare/Med | licaid, 42 CFR | | | | | | |
| | Subpart 483.70 | O(a), Life Safety from | | | | | | |
| | Fire and the 20 | 000 edition of the | | | | | | |
| | National Fire I | Protection | | | | | | |
| | Association (N | JFPA) 101, Life | | | | | | |
| | ` | LSC), Chapter 19, | | | | | | |
| | ` | * * | | | | | | |
| | Existing Health Care Occupancies | | | | | | | |
| | and 410 IAC 1 | 0.2. | | | | | | |
| | | | | | | | | |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | | | | | TITLE | | (X6) DATE | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

J0R321

Facility ID:

000034

If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2011 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: 155086 | | (X2) MULTIPLE CC A. BUILDING B. WING | 01 | COMP 04/20/ | LETED | | | |
|---|--|--|--|--|--------|----------------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN46514 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY) | JLD BE | (X5) COMPLETION DATE | | |
| | construction as sprinklered. To alarm system with the corridors capacity of 80 66 at the time. Quality Review by Safety Code Special 04/25/11. The facility was compliance with aforementione. | be of Type II (111) nd was fully The facility has a fire with smoke detection is and spaces open to the facility has a such and had a census of of this survey Robert Booher, REHS, Life dist-Medical Surveyor on the survey is found not in the facility has a survey in the surveyor on the surveyor or t | | | | | | |

000034

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | | | | | ATE SURVEY | | |
|--|---|--|--------|--|--|--------|--------------------|--|--|
| AND PLAN OF CORRECTION | | | | ILDING | 01 | | MPLETED | | |
| | 155086 | | B. WIN | B. WING 04/20/ | | | 2011 | | |
| NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | |
| WOOD! AND MANOD | | | | 343 S NAPPANEE ST ELKHART, IN46514 | | | | | |
| | WOODLAND MANOR | | | <u> </u> | R I, IIN400 I4 | | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) | | |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | COMPLETION DATE | | |
| K0029 | | d construction (with ¾ hour | | 1110 | | | DATE | | |
| SS=E | fire-rated doors) or | r an approved automatic fire | | | | | | | |
| | | em in accordance with 8.4.1 | | | | | | | |
| | When the approve | otects hazardous areas. | | | | | | | |
| | | em option is used, the areas | | | | | | | |
| | | n other spaces by smoke | | | | | | | |
| | | and doors. Doors are on-rated or field-applied | | | | | | | |
| | • | hat do not exceed 48 inches | | | | | | | |
| | | f the door are permitted. | | | | | | | |
| | 19.3.2.1 Based on obse | rvation and | K | 0029 | K029 | | 05/06/2011 | | |
| | interview, the facility failed to | | | | | | | | |
| | | storage room doors | | | Our facility strives to provide | the | | | |
| | serving hazardous areas for Unit 1 closed and latched to prevent the passage of smoke. This deficient | | | | best | | | | |
| | | | | care possible. In accordance with that policy, we have addressed | | | | | |
| | | | | | the following issue. | | | | |
| | - | affect residents, | | No residents were affected. | | | | | |
| | * | aff in and near the | | | | d. | 1 | | |
| | | an in and near the | | | | | | | |
| | storage room. | | | | | | | | |
| | Findings in also | J | | | An automatic door closer and latch was installed on the door to unit 1 storage room on 5/2/11. | | | | |
| | Findings inclu | de: | | | | | | | |
| | D 1 1 | | | | | | | | |
| | | rvations with the | | | | | | | |
| | maintenance si | • | | | | ı | | | |
| | | 40 p.m., the door to | | | Maintenance Director was | | Ϊ | | |
| | the Unit 1 storage room containing cleaning supplies and chemicals did not have a door closer and did not automatically close and latch. The storage room contained boxes and | | | | educated on the proper maintenance for the unit 1 supply room door closer to ensure door automatically closes and latches. | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | ľ | J I | | |
| | plastic contain | ers of cleaning | | | The Maintenance Directo | r will | | | |
| FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: J0R321 Facility ID: 000034 If continuation sheet Page 3 of 6 | | | | | | | | | |

| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|------------------------------|---|--|----------------------------|---|---|------------|------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILDING 01 | | 01 | COMPLETED | |
| 15508 | | 155086 | B. WIN | | | 04/20/2011 | |
| | | | B. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF PROVIDER OR SUPPLIER | | | 343 S NAPPANEE ST | | | | |
| WOODLA | AND MANOR | | | | RT, IN46514 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | E | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENCY) | | DATE |
| | supplies. The | maintenance | | | check the unit 1 supply room closer is functioning properly | | |
| | supervisor acknowledged the problem at the time of observation. | | I I | | weekly for 2 months, bi-week | | |
| | | | | 2 months, monthly for 2 months | | | |
| | proofein at the | time of observation. | | | and as needed when deemed | | |
| | | | | | necessary by the QA commit | tee. | |
| | 3.1-19(b) | | | | | | |
| | | | | | | V | |
| | | | | | | | |
| | | | | | 5/6/2011 | | |
| K0144 | | spected weekly and and for 30 minutes per | | | | | |
| SS=F | month in accordan | • | | | | | |
| | 3.4.4.1. | | | | | | |
| | Based on record review and | | K0144 K144 | | K144 | | 05/06/2011 |
| | interview, the | facility failed to | | | | | |
| | ensure 1 of 1 emergency generators | | | | Our facility strives to provide | the | |
| | | with remote manual | | best care possible. In accordance wit | | | |
| | | | | | | | |
| | stops. LSC 7.9 | _ | | that policy, we have addressed the following issue. | | | |
| | | nerators providing | | | and remember 19 is a second | | |
| | power to emer | gency lighting | | | | | |
| | systems shall b | be installed, tested | | | No residents were affecte | d. | |
| | and maintained | d in accordance with | | | | | |
| | | andard for Emergency | | | | II | |
| | · · | 0 , | | | Remote shut off device wa | as | |
| | | ower Systems. NFPA | | | installed on 5/6/11. | | |
| | | ion, 3-5.5.6 requires | | | | | |
| | Level II install | lations shall have a | | | | | |
| | remote manual | l stop station of a | | | Maintenance Director was | III S | |
| | | a break-glass station | | | educated regarding generato | | |
| | • • | • | | horse power and proper usage | | ge of | |
| | located elsewhere on the premises | | | | the remote shutoff device | | |
| | _ | ne mover is located | | | installed for the generator. | | |
| | outside the bui | ilding. NFPA 37, | | | | | |
| | | | | | | IV | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | X1) PROVIDER/SUPPLIER/CLIA | 01 | | ì í | DATE SURVEY COMPLETED | | |
|---|--|--|-------------------|--|--|-----------------------|--------------------|--|
| AND FLAN OF CORRECTION | | 155086 | | LDING | | 04/20/20 | | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | 0 11/20/20 | | |
| NAME OF PROVIDER OR SUPPLIER | | | 343 S NAPPANEE ST | | | | | |
| WOODLAND MANOR | | | ELKHART, IN46514 | | | | | |
| (X4) ID PREFIX | SUMMARY STATEMENT OF DEFICIENCIES | | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION | |
| TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | DATE | | |
| | Standard for the Installation and Use of Stationary Combustion | | | | The Maintenance Directo | | | |
| | | | | | check remote shut off device weekly for proper functioning | | | |
| | Engines and G | as Turbines, 1998 | | months, bi-weekly for 2 months, monthly for 2 months and as needed when deemed necessary | | | | |
| | _ | .2(c) requires engines | | | | | | |
| | of 100 horsepo | ower or more have | | | by the QA committee | | | |
| | provision for t | he shutting down the | | | | | | |
| | engine at the e | engine and from a | | | | V | | |
| | remote locatio | n. This deficient | | | 5/6/11 | | | |
| | practice could affect all residents, staff and visitors in the event of an emergency. | | | | 3/0/11 | | | |
| | | | | | | | | |
| | | | | | | | | |
| | Findings include: | | | | | | | |
| | Based on revie | ew of the Generator | | | | | | |
| | Maintenance r | ecords on 04/20/11 at | | | | | | |
| | 12:25 p.m. wit | th the maintenance | | | | | | |
| | supervisor, the | ere was no | | | | | | |
| | documentation | available which | | | | | | |
| | indicated the h | orsepower rating of | | | | | | |
| | the generator e | engine. Based on | | | | | | |
| | interview with the maintenance supervisor, he stated no remote shut off device existed for the generator, furthermore, the maintenance supervisor indicated he was not sure if the generator was 100 horsepower or more. The | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | maintenance s | upervisor indicated | | | | | | |
| | | | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| | of Correction identification number: 155086 | (X2) MULTIPLE CC A. BUILDING B. WING | 01 | COMPLETED 04/20/2011 |
|--------------------------|--|--|---|---------------------------------------|
| | PROVIDER OR SUPPLIER AND MANOR | 343 S N | ADDRESS, CITY, STATE, ZIP CODE NAPPANEE ST RT, IN46514 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ION (X5) D BE COMPLETION DPRIATE DATE |
| | the generator was installed before 2003. | | | |
| | 3.1-19(b) | | | |
| | | | | |
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